General Filing Instructions For HMO or HCSC Forms

1. **Question: What Are General Filing Instructions And What Do They Apply To?**

   Answer: The purpose of this document is to clarify how licensed health carriers are to file contract forms, rate schedules, and modifications to contracts and rates with this office. For purposes of these general filing instructions a licensed health carrier is a:

   a. **Health Care Service Contractor** licensed per RCW 48.44
      - These carriers offer prepaid health plans and are subject to all state mandates.

   b. **Limited Health Care Service Contractor**, licensed per RCW 48.44
      - These carriers offer "limited" prepaid health plans such as dental or vision only benefits.

   c. **Health Maintenance Organization**, licensed per RCW 48.46
      - These carriers offer comprehensive health medical plans and are subject to state mandates pertaining to HMOs.

   The above licensed health carriers are subject to numerous filing requirements that are dependent on the type of health care products marketed.

2. **Question: Why Must A Carrier Conduct Business In Its Licensed Name?**

   Answer: RCW 48.44.040 requires health care service contractors (HCSCs) to register with the Office of the Insurance Commissioner (OIC). RCW 48.44.015 states that no one may act as a health care service contractor without first being registered with the OIC. RCW 48.44.016(3) states anyone who knowingly violates RCW 48.44.015(1) is guilty of a class B felony.

   RCW 48.46.040 requires health maintenance organizations (HMOs) to register with the Office of the Insurance Commissioner. RCW 48.46.027(1) states that no one may act as a health maintenance organization without being registered with the Office of Insurance Commissioner. RCW 48.46.033(3) states that anyone who knowingly violates RCW 48.46.027(1) is guilty of a class B felony.

   Due to the above statutes and this office's responsibility to ensure health plans are being administered correctly, carriers must conduct business in its licensed name. For example, the following forms must clearly indicate the correct name of the licensed carrier:

   - All enrollment forms or change forms
   - All group master application forms
   - All contracts
   - All certificates of coverage
   - All summaries of benefits
   - All collateral documentation, handouts, marketing materials
   - All member identification cards, explanation of benefits, etc.
   - All provider agreements

3. **Question: How Should A Filing Be Submitted?**

   Answer: With the exception for certain network reports, all filings should be submitted in camera ready format. Standard Master Filings should include a strike-out copy listing the changes (*Please see questions 21 & 22 pertaining to the replacement process for small group and individual filings*). Please note our office

images all filings. Therefore, we ask that carriers not submit duplicate filings when making a form submission. It is not acceptable to file form or rate filings in the following manner:

- **In Draft Format.** All filings should be in final format.
- **In Binders.** All filings should be filed with a single rubber band or clip. Please do not use multiple staples or paper clips when submitting a filing.
- **In Multiple Pieces.** Filings should be submitted as a complete submission. Our office does not have the resources to collate replacement pages or benefit changes for filings already submitted for review.
- **Marked As Confidential.** With the exception of "not for public" rate filings, all documents on date received are subject to public disclosure; therefore, they cannot be filed as confidential.

4. **Question: What is a Standard Master Contract?**

Answer: Standard Master Contracts are the "core" or off the shelf contracts filed for small or large groups per the 18-month timeframes of WAC 284-43-920.

a. Standard Master Contracts **must** contain a group master enrollment application, individual enrollee/member application, rates, certificate of coverage (COC) and **may** contain riders that offer additional benefit options.
b. Standard Master Contracts are considered "off the shelf" products. This means all products that contain a standard set of benefits sold to a group or sole-proprietor for a rate that is not subject to negotiation. These forms **must be** filed before you can offer them, including filing any modifications you make (RCW 48.44.040, RCW 48.46.060). Contract modifications must be identified in a separate copy containing underlines, highlights or strikeouts on the contract form.
c. Standard Master Contracts must be re-filed no later than 18 months from the effective date requested on the transmittal form (WAC 284-43-920). [**Note: The cover letter must state this is an 18-month filing with a summary of the major changes.**]
d. Please note that new plans require an Access Plan be filed as well (WAC 284-43-210).
e. The OIC prefers standard master contracts be submitted 90 days prior to the effective date.

5. **QUESTION: What Are Negotiated Group Contracts?**

ANSWER: A negotiated group contract is unique to a specific group or association. Please note that while *Washington State law requires every standard master contract, certificate of coverage, application, rate, and endorsement/rider to be filed prior to use;* negotiated contracts must be filed within 30 days after the completion of negotiations or renewal premiums are implemented (see WAC 284-43-920). Filings received after this timeframe may be subject to enforcement.

Please note there are two ways to file negotiated contracts. They are as follows:

a. **Short Form Filings** - A contract with 12 or fewer deviations from the current standard master contract. The OIC has termed this method of filing a "short form" because the entire contract is not required to be filed.

   To speed products to market and expedite the review process, the OIC agrees small variations in negotiated contracts do not materially alter the standard master contract on file. These variances will be allowed as "deviations" as long as these variances are identified in a "short form" filing. For example, deviations might include: "for public rates", alternate language from the standard master, different copayments, coinsurance, association or trust paperwork, etc.

   Please note, endorsements are not generally accepted for short form filings.

b. **Fully Negotiated Group Contracts** - A contract with 13 or more deviations from the standard master contract form. You must file a fully negotiated group contract including the required documents.

Short Form Filings or Fully Negotiated Group Contract Filings must include the rate schedule and the experience report of WAC 284-43-950 with corresponding transmittal. You do not need to file WAC 284-43-950 under the following exception:

Exception: You may request to file annually an actuarial memorandum or rate manual that includes rating methodologies you use to determine large or negotiated group rates. If you have such a request on file and the large or negotiated group rates are based on the filed rating methodology, you do not need to include WAC 284-43-950 in your short form or fully negotiated filing.

6. **QUESTION: What Generally Must Be Included In A Short-Form Or A Fully Negotiated Filing?**

Answer: Filings must include the following--

a. A transmittal (INS-1120) for the *contract* and a ***separate*** transmittal for the *Proprietary Rate* (WAC 284-43-950).

b. A cover letter containing the standard contract number that is the master for this negotiated contract and a specific list of deviations showing how the negotiated filing differs from the standard master contract. Please incorporate an explanation of the deviation or provide the page of the contract that includes the deviated language.

c. For Association, Trust, and Member governed group contracts, the cover letter must include the following:

   i. Purpose of the Association or Trust (By-laws)

   ii. Attach or list eligibility rules for membership in the Association or Trust including membership fees if any.

   iii. Attach or list eligibility rules for purchasing coverage through the Association or Trust.

      1) The "For-Public" rate.

      2) A completed "Groups Other Than Small Groups Filing Summary" as described at WAC 284-43-950.

d. Fully negotiated filings must also include enrollment forms, certificate of coverage, and the contract.

e. A copy of the cover letter for the proprietary rate filing.

7. **QUESTION: What Is A Rider, An Amendment, An Endorsement?**

ANSWER: A Rider is typically an additional offering or exclusion that is included in a policy at the time of issue. For example, a pharmacy rider might be attached to a health plan policy. An Amendment typically changes a certificate of coverage already in force. For example, an amendment might be added explaining that the benefit for chemical dependency might increase mid-year through a health plan. An Endorsement, similar to an amendment, adds or removes contract language to an in-force health benefit plan.

8. **QUESTION: What Is A "Blanket Endorsement"?**

ANSWER: A "Blanket Endorsement" is an endorsement that applies to most of your existing contracts. It is used to endorse multiple contracts due to changes in state or federal law. A Blanket

Endorsement may also be used to bring multiple contracts into compliance using a single filing submission.

Please note a Blanket Endorsement is not for use with a single contract and should not be confused with a rider.

9. **QUESTION: How Do I File A Blanket Endorsement?**

ANSWER: To file a blanket endorsement you must include:

a. A cover letter that clearly states this is a blanket endorsement applying to the contracts listed on the transmittal.

b. Complete one transmittal listing the endorsement number for each applicable Line of Insurance box(es) *and* complete Section 22 "**Additional Form Numbers**" listing all applicable contracts.

c. A rate filing is required in conjunction with the endorsement if a new or modification of the benefit affects the rate. If the rate is not affected, please note such in the cover letter.

10. **QUESTION: How Do I file A Provider Agreement?**

ANSWER: All Participating Provider, Facility and Subcontractor (template) Agreements require prior approval and must be filed at least 15 working days prior to intended date of use (Please note the OIC would prefer at least 30 days). Agreements may not be executed until they have first been filed, and until the carrier has either received a letter advising that the form has been approved for use or the agreement has been deemed approved in accordance with RCW 48.46.243(3)(b), RCW 48.44.070(2) and WAC 284-43-330.

A material change to an approved agreement requires:

a. Submission of the new template with any modifications. Please include a second copy that includes underlines, highlights or strikeout language with the modified template.
b. Submission of the addendum to be sent to contracted providers, if any.

Please note if a provider network is subcontracted then the agreement between the carrier and network as well as the agreement between the network and provider must be filed with this office. Additionally, per RCW 48.43.550, WAC 284-43-120 and WAC 284-43-300, the health carrier is held accountable for the actions of its subcontractors.

11. **QUESTION: What Is A Small Group?**

ANSWER: RCW 48.43.005(24) defines a small group as having at least two but no more than fifty eligible employees. Health plans offered to small employer groups must be filed with this office prior to use and be community rated.

12. **QUESTION: How Do You Count Employees To Determine If A Group Qualifies As A Small Group?**

ANSWER: Per RCW 48.43.005(10), an eligible employee is one who works on a full-time basis with a normal work week of 30 or more hours. Per RCW 48.44.023 (RCW 48.46.066(5) for HMOs), a health care contractor (or HMO) shall not require a minimum participation level greater than 100% of eligible employees working for groups with 3 or less employees; and 75% of eligible of eligible employees working for groups with more than 3 employees.

The participation level is based on the number of employees actually covered under the plan divided by the number of eligible employees. Please note that a small employer shall not include employees or dependents that have similar existing coverage when calculating the applicable percentage of participation is met. When calculating participation levels, employees with other coverage are not considered eligible employees.

13. QUESTION: What Are Network Reports?

Answer: There are four different reports that **must** be filed by health carriers.

They are as follows:

a. **Provider Network Form A** as required by RCW 48.44.080, RCW 48.46.030, & WAC 284-43-220. This monthly report is submitted electronically and contains data on contracted providers.
b. **Enrollee Network Form B** as required by WAC 284-43-220. This report is filed electronically on an annual basis and contains enrollment information by county per line of business.
c. **Access Plans** as required by WAC 284-43-210 & WAC 284-43-220. Please note that an Access Plan is required to be filed prior to offering a new health plan or when there is a material change to an existing health plan. Access Plans must be filed in hard copy format.
d. **Geographic Network Report** as required by WAC 284-43-220. This annual report is a geographic representation of enrollees and providers. This report may be filed electronically or via hard copy.

Please see our WEB page at: http://www.insurance.wa.gov/industry/mainhealthcare.asp for instructions.

14. QUESTION: What Are Conversion Plans?

ANSWER: Conversion plans are required to be offered to members who have lost coverage under their group health plan. These plans are part of the "state alternative mechanism" required by the federal government ensuring access to health care. Because conversion plans are not "true" individual plans they are not subject to the replacement of contract language provided in RCW 48.43.038 or the group requirements of RCW 48.43.035. Please note, however, that as part of the state alternative mechanism, once a conversion plan is issued it must continually be renewed.

15. QUESTION: What Are "Analyst Checklists?"

ANSWER: Analyst Checklists identify required elements that must be contained in a document filed with this office. Our staff completes these forms to ensure consistent reviews. Please note that the checklist is a tool listing the various legal requirements that must be contained in a filing, however, the analyst checklist is not meant to represent every law that might impact the filing. Copies of these checklists may be obtained at the following website:

http://www.insurance.wa.gov/industry/mainhealthcare.asp

16. QUESTION: How Do We Obtain A Status Of A Filing?

ANSWER: Carriers' can check the status of their filings by contacting the Rates and Forms Help Desk at (360) 725-7111 or via e-mail at mailto:RFHelpDesk@oic.wa.gov.

17. QUESTION: How Do We Obtain Confirmation of Final Action?

ANSWER: If you want notice that your submission has been processed you must submit a duplicate transmittal form (INS-1120) and cover letter. We will stamp and code these after we

process your filing and return them to you if you have provided a self-addressed stamped or metered envelope. Please do not provide duplicate copies of filings. They will not be returned.

If at a later date you need copies of a filing you may contact Public Records at 360-725-7000. Copies of these documents are available from our website or you may request hard copies that are subject to copying costs.

18. QUESTION: What Is The Definition Of Guaranteed Issue?

ANSWER: Guaranteed issue, specifically for group health plans, is regulated by RCW 48.43.035. Health carriers shall accept for enrollment any state resident within the group to whom the plan is offered and within the carrier's service area and provide or assure the provision of all covered services regardless of age, sex, family structure, ethnicity, race, health condition, geographic location, employee status, socioeconomic status, other condition or situation, or the provisions of RCW 49.60.174(2).

19. QUESTION: What Is "Guarantee Of Continuity Of Coverage" For *Individual* Health Plans?

ANSWER: Individual health plans are governed by RCW 48.43.038. Individual health plans are guaranteed continuity of coverage meaning the carrier cannot terminate coverage, except for:

- There is a non-payment of premium
- Violation of published policies approved by the insurance commissioner
- Member becomes eligible for Medicare
- Covered person fails to pay any deductible or copayment amounts owed to the carrier and not the provider of health care services
- Change or implementation of federal or state laws
- Covered person commits a fraudulent act against the carrier
- Covered persons who materially breach the health plan

20. QUESTION: What Is "Guaranteed Renewable" For *Group* Health Plans?

ANSWER: Group health plans are governed by RCW 48.43.035. The carrier may consider the group's anniversary date as the renewal date for compliance purposes. Group health plans are guaranteed renewable meaning the carrier cannot terminate coverage, except for:

- There is a non-payment of premium
- Violation of published policies approved by the insurance commissioner
- Member becomes eligible for Medicare
- Covered person fails to pay any deductible or copayment amounts owed to the carrier and not the provider of health care services
- Change or implementation of federal or state laws
- Covered person commits a fraudulent act against the carrier
- Covered persons who materially breach the health plan

21. QUESTION: What Triggers The Replacement Process?

ANSWER: Any change to a contract or certificate of coverage may trigger replacement. This includes carriers that are considering modifying a product by adding, deleting, modifying or replacing language; therefore, carriers should first verify with the OIC if the carrier will be subject to the replacement requirements.

If a carrier changes benefits or language, it is replacing its products and must provide the following:

- Must provide notice 90 days in advance of renewal date to the affected individual/groups offering the individual/group to enroll in any other health plan. For group plans this means the 90-day notice must be sent 90 days prior to the group's renewal date.
- Participants of individual plans may transfer to any open individual plan without completion of the standard health questionnaire. See RCW 48.43.038(3)(c).
- Participants of group plans (up to 200 employees) including small group plans must be allowed opportunity to enroll in any available open plan. See RCW 48.43.035(4)(c).

Note: The OIC appreciates submission of strike-out language on replacement products indicating all changes made.

22. QUESTION: When Are Changes To A Contract Not Subject To The Replacement Process?

ANSWER: Changes to group contracts are not subject to the replacement process when:

- The carrier has zero enrollment on a product
- The carrier notifies the OIC with 180 days advanced notice that the carrier is withdrawing from the state in which case notice must be provided to covered members currently on health plan. This notice must be calculated 180 days prior to the renewal date.
- There is a change or implementation of federal or state laws

Note: The OIC appreciates submission of strike-out language indicating changes made due to implementation of state or federal law.

23. QUESTION: What Are "State Mandates"?

ANSWER: Mandated health benefits are developed under the provisions of Chapter 48.47 RCW. Per RCW 48.47.010(7), a mandated benefit means coverage or offering required by law to be provided by a health carrier to: (a) cover a specific health care service or services; (b) cover treatment of a specific condition or conditions; or (c) contract, pay, or reimburse specific categories of health care providers for specific services.

Mandated benefit offerings and coverage are dependent on the type of product marketed. For example, carriers marketing catastrophic individual plans are not required to offer maternity coverage; however, the carrier must market at least one individual plan that does cover maternity.

For additional reference, please see the analyst checklist developed for the specific line of business.

24. QUESTION: How Can We Learn About "State Mandates"?

ANSWER: The required state mandated benefits for a particular line of business can be identified by reviewing the "Analyst Checklist" developed for that line of business. These checklists may be located on our web page at:

http://www.insurance.wa.gov/industry/mainhealthcare.asp

Additionally, the legislative page for the State of Washington contains the specific RCW or WAC for the mandated benefit. The web site also provides notices of forthcoming notices, meetings, and changes to rules. The state legislative page is:

http://www1.leg.wa.gov/LawsAndAgencyRules/

25. **QUESTION: How Are Groups Rated?**

ANSWER: Small group health plans are community rated and the medical experience of all small groups must be pooled for rating purposes. Carriers usually file one small group rate filing every 12 to 18 months. There are no particular rating requirements for the HCSC and HMO large groups. Carriers can file multiple rating methodologies for different kinds of large group pools, or a single case rate filing for a particular negotiated group. Please note that conversion policy rates should be generally included with small group ratings.

26. **QUESTION: When Are Rates Required to be Filed?**

ANSWER: Per WAC 284-43-920, rates are required to be filed before a new contract is offered for sale to the public. Additionally, rates must be filed for negotiated contracts within 30 days of the completion of negotiation. Or, every 18 months for forms that have not changed over that time period.

27. **QUESTION: How Do I File A Proprietary Rate Filing?**

ANSWER: Per RCW 48.02.120(3), in order to preserve trade secrets and prevent unfair competition, carriers may request certain documents related to rate development to be withheld from public inspection. Carriers must include a filing transmittal and identify those materials that are desired to be non-public by separately marking or stamping "proprietary" or "nor-for-public" **on each page of the documents.**

28. **QUESTION: Why Is There A New Transmittal For HCSCs And HMOs?**

ANSWER: The current transmittal has been used over the past 6 years. However, due to recent changes in law affecting the Basic Health Plan "look a likes" and the "Small Group Limited Benefit Plans", this office found that the transmittal needed to be updated. Additionally, some carriers voiced confusion over how "collateral" documents such as disclosure forms should be filed. Based on these industry concerns, the transmittal was modified so that there is now an additional page just for the filing of these extra forms.

29. **QUESTION: When Must We Start Using The New Transmittal?**

ANSWER: The new transmittal will be accepted by this office immediately. Our office will require all HMO/HCSC filings to be submitted on the new transmittal effective August 1, 2006.

30. **QUESTION: What Are The Major Changes Incorporated In The New Transmittal?**

ANSWER: Due to recently enacted legislation, the transmittal was updated to include the "small group limited schedule of benefits" plan. For association type group plans, check boxes were incorporated showing that trust, union, or association paperwork (bylaws) is submitted with the filing. Because of the growing number of forms being submitted for review, a second page was added so that the additional form #'s can be listed.

Please note the new "additional forms" page is required with all submissions. Any filing received without this page will be considered incomplete and returned by the Technician Unit for completion, regardless if the form is populated or not.

31. **QUESTION: What Does The Term "Static" Plan Mean?**

ANSWER: This term is generally used when discussing small group standard master contracts. RCW 48.44.023 and RCW 48.46.066 define that a carrier must uniformly apply coverage to all small employers applying for coverage or receiving coverage from the carrier.

32. **QUESTION: Does The Requirement To Offer "Static" Plans In The Small Group Market Restrict Variable Provisions?**

ANSWER: Yes. Carriers must offer every small employer group the same benefit plan options. There are two exceptions for variable language. First, is mandated benefit offerings in state law. For example: Temporomandibular Joint Disorder coverage. A carrier may file variable language to account for election or rejection of the benefit. Second, a carrier may offer "limited benefit" coverage riders. For example, a carrier may offer a dental rider or vision rider.

Please be careful when designing your small group plans. Variable provisions such as multiple copay, coinsurance, or eligibility conditions are NOT acceptable. If you have any questions about what may be acceptable, please contact your Analyst for assistance.